PRINCIPALS

The State of Tennessee; TennCare enrollees and their attorneys, George Barrett and Ted Carey; the Tennessee Hospital Association; the Hospital Alliance of Tennessee; and major individual stakeholders and providers including the Regional Medical Center at Memphis, Erlanger of Chattanooga, Nashville General Hospital at Meharry, Methodist Healthcare of Memphis, Baptist Memorial Health Care of Memphis, Saint Francis of Memphis, Wellmont Health Systems of Kingsport and the University of Tennessee Medical Group.

SUMMARY

The State has reached a tentative agreement with the above TennCare enrollee attorneys and stakeholders that would preserve health coverage for approximately 97,000 "medically needy" enrollees — the sickest and neediest who generally don't qualify for Medicaid — in exchange for legal relief from the Grier Consent Decree. The agreement also would increase the current proposed four-prescription per month limit for enrollees to five prescriptions per month (three generic, two brand-name).

The tentative agreement is contingent on approval by U.S. District Court Judge John Nixon, the federal judge overseeing the Grier case, and on approval by the U.S. Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees Medicaid programs. The agreement also is contingent on whether U.S. District Court Judge William J. Haynes, the federal judge overseeing another consent decree, issues rulings that undermine the financial stability of the TennCare program.

The State has worked since December to find a way to preserve coverage for as many Tennesseans as possible. In the end, the catalyst for the tentative agreement was the April 12 decision by the U.S. Sixth Circuit Court of Appeals, which cleared the path for the disenrollment of 323,000 people from TennCare. The ruling dispelled uncertainty surrounding the State's ability to reduce enrollment, and prompted some enrollee attorneys and stakeholders to reach the agreement, which had been under discussion for months.

If approved, there would be an upfront cost to the tentative agreement. Maintaining health coverage for nearly one-third of the enrollees slated for disenrollment would require an estimated $100 million — approximately $75 million in one-time money and approximately $25 million in recurring funds. However, negotiated changes in Grier would yield offsetting cost-savings in the future by restoring the State's ability to control costs in TennCare and enabling it to put in place reasonable benefit limits in line with other states.

CONDITIONS

The tentative agreement hinges on federal court approval of changes in the Grier Consent Decree, which currently prevents the State from controlling costs in TennCare. Specifically, the agreement depends on the elimination of "a number of restrictions extending beyond the requirements of federal law" and the implementation of federally approved cost-control measures including:

1) A binding prior-authorization program for prescription drugs and a more extensive preferred drug list (PDL) that would allow the State to "deny any claim for reimbursement for a drug for which prior authorization is required but has not been obtained." Currently, the State cannot enforce prior authorization.

2) The ability to deny claims — similar to private health plans — when benefit limits have been reached. A five-prescription per month limit would provide for three generic prescriptions as well as two brand-name prescriptions that would be subject to prior authorization under the PDL. The State would not pay for any prescription drug when comparable substitutes are available over-the-counter. Currently, the State cannot enforce limits on the quantity or type of service, including brand-name drugs.

3) Changes in the appeals process consistent with state and federal law, including elimination of provisions that place the burden of proof in an appeal on the State (in most states, the burden is on the enrollee) and require the State to pay for services such as prescription drugs until an appeal is exhausted (which generally takes longer than the course of treatment). The State still would be required to pay for a three-day supply of prescription drugs, in the event of an emergency.

The tentative agreement also calls for the Grier Consent Decree to terminate in July 2007 (at the same time the State's current TennCare "waiver" with the federal government expires), unless the federal court determines there are "ongoing or imminently likely" violations of federal law.

NET RESULT

If the tentative agreement is approved by the federal court, TennCare enrollment cuts would be reduced to approximately 226,000 adults (children will not be affected). The remaining adult groups losing coverage would include:

- 121,000 uninsured adults (mostly healthy individuals who conceivably could obtain insurance elsewhere).
- 67,000 uninsurable adults (individuals who at one time could not obtain health insurance but now will be eligible to transfer coverage under federal HIPAA rules).
- 38,000 waiver dual eligibles (individuals who already are covered under the federal government's Medicare program and who will receive prescription-drug benefits through Medicare on January 1).

26 April 2005

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Edmund L. Carey, Jr., Esq.
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Dear George and Ted:

I am very gratified that you have agreed, on behalf of your clients, to work with me to initiate a new Waiver-Based Spend Down program. If we get the necessary approvals, the program we have designed together will preserve TennCare coverage for the neediest and most fragile category of enrollees slated to lose coverage under the TennCare reform plan announced in January. Thank you for working with the State to make this program a possibility for approximately 100,000 Tennesseans by the end of FY 2007.

As you know, the State's ability to provide this relief depends entirely upon reforms to the *Grier* consent decree and the absence of any new restrictions in the *Rosen* or *John B.* cases. The State's ability to provide coverage under the new Waiver-Based Spend Down program also depends upon the assumption that there will be no material changes in the underlying economics of the program, such as the loss or significant reduction of federal funding.

I wanted to give you my own sense of how I intend to assess the underlying economics of the program. I continue to believe that TennCare cannot consume an ever increasing share of the State's limited resources at the expense of all of the other important responsibilities of the State. At the same time, I proposed in this year's budget and continue to believe that the TennCare program's share of the State's budget should not be reduced relative to our other commitments.

Accordingly, it is my intention to look to the percentage of the Department of Revenue's tax collections consumed by TennCare as the primary measure of the underlying economics of the program. So long as that percentage does not increase appreciably above the current 26 percent, I would not consider there to be any material change in the underlying economics that would justify modification or termination of the new Waiver-Based Spend Down program. At the same time, if our joint efforts to reform *Grier* produce additional savings beyond those currently estimated, or if the State otherwise enjoys a positive change in the underlying economics of the program or of the State such that the percentage of total tax revenues consumed by TennCare falls appreciably below the current 26 percent, I will urge the General Assembly to put those savings into the TennCare program to return the spending level to approximately 26 percent. While I have not proposed and do not expect any such measure, in the event the General Assembly were to enact a new revenue stream dedicated to a

particular use or program other than TennCare, I would not seek to divert any of those funds to the TennCare program.

Finally, as I have told you and said publicly many times, no one regrets more than I that there still will be many Tennesseans disenrolled who since 1994 have come into the TennCare program because they were unable otherwise to obtain health insurance coverage. I find solace in the fact that our new initiative should address the needs of the most needy and fragile among them. I find some further solace in the fact that many of these Tennesseans will have the opportunity, due to the "portability" protections of the federal HIPAA law, to obtain alternate coverage in the commercial market without being barred, as they once were, by pre-existing medical conditions. I recognize that this cannot be a solution for everyone, and pledge to you that through the State's safety-net task force initiatives and other efforts the State will continue to pursue its long-term and continuing priority of finding ways, within available resources, to assist our citizens with the health problems particularly associated with being uninsurable and underinsured.

The assurances contained in this letter are effective for the same period as our Memorandum of Understanding. Again, I am delighted that we have found a way to work together to preserve health coverage for the neediest of our fellow citizens.

Warmest regards,

Phil Bredesen

MEMORANDUM OF UNDERSTANDING

M.D. Goetz, Jr., in his official capacity as Commissioner of the Tennessee Department of Finance and Administration, *et al*., defendants in *Grier v. Goetz*, No. 79-3107 (M.D. Tenn.); Sanford Bloch, *et al.*, plaintiffs-intervenors in *Grier*; the Tennessee Hospital Association, defendant-intervenor in *Grier*; the Hospital Alliance of Tennessee, defendant-intervenor in *Grier*; and the Regional Medical Center at Memphis, *et al*. (the "Provider Amici"), *amici curiae* in *Grier*, by and through their undersigned counsel, hereby agree as follows:

1. Creation of New Waiver-Based Spend Down Program. If all of the conditions precedent set forth in paragraphs 3 through 6 are satisfied, the State of Tennessee will initiate a new Waiver-Based Spend Down program designed to provide coverage for the neediest enrollees who will be losing TennCare coverage under the State's TennCare reform plan. The new program will have the following characteristics:

a. The State will establish, at the State's sole discretion, eligibility criteria for the Waiver-Based Spend Down program (or for any interim Medicaid Medically Needy program while the waiver-based program is being established) modeled on the optional Medicaid Medically Needy category. Such criteria may include an eligibility period of 3 months and enrollee spend down criteria based on incurred medical expenses from the 30 days prior to application only. The State also retains full discretion to set other criteria such as an appropriate asset test, threshold spend down level, base income level, and enrollee spend down criteria.

b. Enrollment in the Waiver-Based Spend Down program (or any interim Medicaid Medically Needy program) in Fiscal Year 2006 will be limited to those non-pregnant adult Medically Needy persons on the current TennCare program as of the date on which the district court in *Grier* grants the consent decree relief specified in paragraph 3. Upon initiation of the Waiver-Based Spend Down program, any such persons who are enrolled in the Medicaid

Medically Needy program will be permitted to request to be transferred to the new category. Once in the new Waiver-Based Spend Down program, each enrollee will complete the remainder of that enrollee's original 12-month term of eligibility in the Medicaid program. At that time, the enrollee must satisfy the Waiver-Based Spend Down program's eligibility criteria to retain coverage.

c. The State will open the Waiver-Based Spend Down program to new enrollment starting in Fiscal Year 2007 with a defined allotment of monthly applications to be accepted by the Department of Human Services. The monthly allotment will be designed to increase enrollment, over twelve months, in the Waiver-Based Spend Down Program to approximately 100,000 enrollees, the pre-reform (i.e., Fiscal Year 2005) level of adult non-pregnant enrollment in the TennCare Medicaid Medically Needy category. Subject to these numerical limits, enrollment will be open starting in Fiscal Year 2007 to any individual who meets the eligibility requirements of the new Waiver-Based Spend Down program, regardless of previous Medicaid or TennCare experience.

d. The Waiver-Based Spend Down program will have the same pharmacy benefit as that offered to TennCare's non-institutionalized Medicaid adult population, which is expected to be five prescriptions per month (two branded and three generic).

e. After December 31, 2005, when the Medicare Part D drug benefit is expected to be available, no further applications from persons who are eligible for Medicare (either currently enrolled or with a pending application) will be accepted into the Waiver-Based Spend Down program. However, those current Medically Needy enrollees receiving long term care services under the TennCare program as of the date on which the district court in *Grier* grants the consent decree relief specified in paragraph 3 will be allowed to apply for coverage under the Waiver-Based Spend Down program regardless of Medicare status.

2. Commitment to Maximize Federal Ryan White Funds. To mitigate some of the effects associated particularly with the disenrollment of the adult HIV waiver population, the state pledges to fully contribute to Ryan White programs through the Department of Health as necessary to maximize available matching federal funding in Fiscal Year 2006.

3. Relief from *Grier* Consent Decree. The State, the plaintiffs-intervenors, the Tennessee Hospital Association, the Hospital Alliance of Tennessee, and the Provider Amici agree that the State's ability to initiate a new Waiver-Based Spend Down program depends upon the adoption of revisions to the *Grier* consent decree that eliminate a number of restrictions extending beyond the requirements of federal law and that bring Tennessee's Medicaid program into line with those of other states. Accordingly, the State's agreement to initiate the new Waiver-Based Spend Down program described in paragraph 1 is contingent upon the State obtaining, by July 1, 2005, modifications and/or clarifications of the *Grier* Consent Decree that are described in this paragraph, all of which the plaintiffs-intervenors, the Tennessee Hospital Association, the Hospital Alliance of Tennessee, and the Provider Amici hereby agree to urge the *Grier* Court to adopt by joining the State's forthcoming motion to modify the consent decree.[1] The modifications and/or clarifications of the *Grier* Consent Decree would provide that, notwithstanding anything to the contrary in the Consent Decree or any other order of the *Grier* Court, the State may implement any of the following reforms to TennCare:

a. The State may implement all reforms not specifically disapproved by the Centers for Medicare and Medicaid Services ("CMS") that were proposed by the State in its September 24, 2004, Proposed Waiver Amendment application to CMS and in its February 18, 2005, Supplement to the September 2004 application, with any modifications resulting from negotiations with CMS.

[1] Pending the completion of discovery, plaintiffs-intervenors reserve the right not to join the State in seeking the modification described in paragraph 3(s).

b. The State may implement a three-tiered prior authorization program and Preferred Drug List/formulary, requiring prior authorization by the TennCare Bureau as a condition of coverage for any drug or drug class so designated by the State, and the State may deny any claim for reimbursement for a drug for which prior authorization is required but has not been obtained.

c. The State may implement a five prescription per month limitation for all non-institutionalized adults pursuant to which at least three prescriptions must be generic, and any branded prescriptions are subject to a Preferred Drug List/formulary pursuant to which non-preferred prescriptions will require prior authorization by the TennCare Bureau as a condition of coverage. The State expects to eliminate the requirement that three prescriptions must be generic upon full implementation of the three-tiered Preferred Drug List/Formulary with prior authorization.

d. When a request for prior authorization for coverage of a drug is denied, the State will issue a notice informing the enrollee of the basis for the denial at the time the request is denied, which may be after the service has been denied by a provider. If the enrollee appeals the denial of prior authorization or coverage, the State will have no obligation to pay for the service during the pendency of any appeal. With respect to pharmacy coverage determinations, the state action from which an appeal may be taken is the State's denial of requested prior authorization. Where no prior authorization has been sought for a drug requiring such authorization in order to be treated as a covered service (and therefore no prior authorization request has been denied), there will be no state action from which a valid appeal can be taken. The State may limit any appeals of denials of prior authorization to disputed issues of fact, including issues concerning whether prior authorization has, in fact, been granted or whether the factual predicate of any denial of prior authorization (including the State's assessment of the medical necessity of a specific, prescribed medication) was erroneous.

e. After consultation with a Pharmacy and Therapeutics Committee established pursuant to Section 1927(d)(4)(A) of the Social Security Act, the TennCare Bureau may make all final decisions concerning the content of the formulary and the designation of drugs available to enrollees as covered services without prior authorization.

f. The State may categorically exclude coverage for any drug for which functionally comparable substitute drugs are available over-the-counter in non-prescription form.

g. The State may refuse to dispense (or to reimburse a pharmacist who dispenses) a prescribed drug (or an interim supply thereof) for which prior authorization is a prerequisite to prescription as a covered service, except that the State will reimburse for a three day interim supply in true emergency situations. Paragraph C(14)(e) of the consent decree (providing that the three day period will revert to 14 days on January 1, 2006) shall be deleted.

h. When the State imposes benefit limits capping the number of in-patient hospital days per year, physician services per year, outpatient facility services per year, laboratory and x-ray services per year, inpatient and outpatient substance abuse services over the course of the enrollee's lifetime, and/or prescriptions per month that will be covered by TennCare, the State may deny any claim for services whenever such service would exceed a benefit limit imposed by the State. When a claim for reimbursement is denied by the State or a managed care contractor ("MCC") because the enrollee has reached the benefit limit, the State will issue a notice informing the enrollee of the basis for the denial at the time the claim is denied (which may be after the service has been denied by a provider). The State need not provide notice when an enrollee is approaching or reaches a benefit limit. A provider's refusal to render a requested service because the enrollee has reached a benefit limit does not, on its own, constitute action by the State, and the State need not provide notice in those circumstances. If the enrollee appeals the denial of coverage, the State may refuse to pay for the service during the pendency of any appeal from the denial. The State may limit any appeals of denials based upon the benefit limits

to disputed issues of fact concerning whether the benefit limit had, in fact, been exceeded, or whether the enrollee was in fact subject to the benefit limit (assuming that such a ground has not been waived pursuant to paragraph 3(j), *infra*).

i. The State may impose and/or increase the co-pays charged for any TennCare service, and the State may deny any claim for services for which the co-pay has not been paid. When a claim for reimbursement is denied, the State may refuse to pay for the service during the pendency of any appeal from the denial. The State may limit any appeals of denials for refusal to pay the co-pay to disputed issues of fact concerning whether the co-pay had, in fact, been paid or was not required. A provider's refusal to provide a requested service because the enrollee did not pay the co-pay does not constitute action by the State, and the State need not provide notice in those circumstances.

j. Upon implementation of any benefit reforms to the TennCare program, if the State provides notice to all enrollees that complies with federal requirements and the terms of the TennCare waiver and the State provides enrollees an opportunity for a hearing on any disputed issue of fact regarding the application of the benefit reform to them (i.e., issues related to their eligibility category), then the State may refuse to consider, as a ground for an appeal of a service denial, challenges to an enrollee's eligibility category that they had the opportunity to raise previously.

k. The State may dismiss an appeal without providing a hearing when the enrollee never requested the item or service sought in the appeal from the MCC in the first instance or when the item or service sought has not been ordered or prescribed by a provider.

l. The State may rely upon all relevant information, not just the enrollees' medical records, in determining TennCare coverage of medical services and in considering and deciding medical appeals. Paragraph C(7) of the consent decree shall be deleted.

m. The State may implement a screening process to identify appeals that are not based upon a valid factual dispute (i.e., an individualized dispute that, if resolved in favor of the enrollee, would entitle the enrollee to coverage of the service sought in the appeal), and dismiss such appeals without providing a hearing.

n. The State may place the burden of proof in all medical appeals upon the enrollee.

o. The State may appeal a medical appeal decision rendered at any stage of the process in favor of the enrollee, consistent with the Tennessee Uniform Administrative Procedures Act.

p. The State may revise the time limitations for filing and resolving medical appeals to conform with federal requirements, and the State may limit expedited appeals to circumstances as required by federal regulations.

q. The State may evaluate all claims for TennCare services in accordance with the definition of medical necessity established by State law (including regulations issued pursuant to the promulgating statute)[2], and the State may deny any claim for a service that the State has concluded is not medically necessary as that term is defined under State law. The State, not a provider, will have the ultimate authority to determine whether a medical item or service that has been prescribed by a provider is medically necessary.

r. The State may implement a reasonable set of geographic and/or clinical hardship criteria to determine when enrollees will be allowed to transfer between MCCs outside of defined open enrollment periods.

s. The *Grier* Consent Decree as revised will terminate at the end of the current term of the State's TennCare waiver unless the Court determines that there are ongoing or imminently

[2] Pending the promulgation of these regulations, plaintiffs-intervenors and Provider Amici reserve the right not to join the State in seeking the clarification of the consent decree described in paragraph 3(q).

likely violations of federal law, in which case the decree will be limited to those provisions of the decree as revised that are necessary to remedy any such violations of federal law.

4. Authority to Implement Eligibility Changes. The State's agreement to initiate the new Waiver-Based Spend Down program described in paragraph 1 is contingent upon the State not being enjoined from issuing the notices necessary to effect the eligibility changes that have been challenged by the plaintiffs in *Rosen v. Goetz*, No. 98-0627 (M.D. Tenn.), which will begin to be issued on or about June 1, 2005, or from implementing the eligibility changes thereafter.

5. CMS Approval. The State's agreement to initiate the new Waiver-Based Spend Down program described in paragraph 1 is contingent upon the State obtaining the approval of CMS to (i) implement the TennCare reforms that were proposed by the State in its September 24, 2004, Proposed Waiver Amendment application to CMS and in its February 18, 2005, Supplement to the September 2004 application, subject to any modifications resulting from negotiations with CMS (including specifically the modification altering the proposed four prescription limit to five prescriptions of which at least three must be generic); and (ii) implement the new Waiver-Based Spend Down program.

6. Appropriation of Necessary Funds. The State's agreement to initiate the new Waiver-Based Spend Down program described in paragraph 1 is contingent upon the Tennessee General Assembly appropriating the additional funds necessary to support the program.

7. Term and Reservations. Subject to the conditions precedent identified in paragraphs 3 through 6, the new Waiver-Based Spend Down program described in paragraph 1 will remain in place at least until the end of the current term of the State's TennCare waiver, provided that, the State may modify or terminate the Waiver-Based Spend Down program if (i) material changes in the underlying economics of the program, including but not limited to the loss or significant reduction of federal funding for the program, occur; or (ii) the State is required

to make material and appreciable changes to TennCare as a result of any new judicial order or decree in *Grier*, *Rosen*, *John B. v. Goetz*, No. 98-0168 (M.D. Tenn.), or any other lawsuit.

AGREED TO THIS 26TH DAY OF APRIL, 2005:

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